

		FOR OHF USE					

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**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0000786</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>VERMILION MANOR NURSING HOME</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12/01/02</u> to <u>11/30/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>14792 CATLIN TILTON ROAD</u> <u>DANVILLE</u> <u>61834</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>VERMILION</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) <u>EDIE HESSER</u> (Title) <u>ADMINISTRATOR</u>	
<b>Telephone Number:</b> <u>217-443-6430</u> <b>Fax #</b> <u>217-443-1558</u>		<b>Paid Preparer</b> (Signed) _____ (Date) _____ (Print Name and Title) <u>SEE ATTACHED ACCOUNTANT'S REPORT</u> (Firm Name & Address) <u>CLIFTON GUNDERSON LLP</u> <u>2 E. MAIN STREET, SUITE 120, DANVILLE, IL 61832</u> (Telephone) <u>217-442-1643</u> <b>Fax #</b> <u>217-443-5470</u>	
<b>IDPA ID Number:</b> <u>37-6002224-001</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> 201 S. Grand Avenue East Springfield, IL 62763-0001 <b>Phone # (217) 782-1630</b>	
<b>Date of Initial License for Current Owners:</b> <u>01/01/1974</u>			
<b>Type of Ownership:</b>			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____		<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input checked="" type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input checked="" type="checkbox"/> County <input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>EDIE HESSER</u> <b>Telephone Number:</b> <u>217-443-6430</u>			

## STATE OF ILLINOIS

Page 2

Facility Name & ID Number VERMILION MANOR NURSING HOME# 0000786 Report Period Beginning: 12/01/02 Ending: 11/30/03

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds 12/23/02

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>50</u>	Skilled (SNF)	<u>138</u>	<u>48,434</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>187</u>	Intermediate (ICF)	<u>95</u>	<u>36,699</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>237</u>	TOTALS	<u>233</u>	<u>85,133</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,820</u>	<u>1,316</u>	<u>7,015</u>	<u>10,151</u>	8
9	SNF/PED					9
10	ICF	<u>42,863</u>	<u>14,191</u>	<u>994</u>	<u>58,048</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>44,683</u>	<u>15,507</u>	<u>8,009</u>	<u>68,199</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 80.11%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)N/AF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 01/01/1974

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date \_\_\_\_\_ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number  
of beds certified 29 and days of care provided 6,382Medicare Intermediary ADMINSTAR

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☐ NO ☐Tax Year: N/A Fiscal Year: 12/01/02-11/30/03

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number VERMILION MANOR NURSING HOME

# 0000786

Report Period Beginning:

12/01/02

Ending:

11/30/03

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	434,481	39,194	17,343	491,018		491,018		491,018			1
2	Food Purchase		327,075		327,075	(18,250)	308,825	(3,473)	305,352			2
3	Housekeeping	136,305	27,546		163,851		163,851		163,851			3
4	Laundry	95,363	19,281		114,644		114,644		114,644			4
5	Heat and Other Utilities			193,508	193,508	(353)	193,155	(11,005)	182,150			5
6	Maintenance		23,673	48,309	71,982		71,982	117,721	189,703			6
7	Other (specify):* <b>WASTE DISPOSAL</b>			13,113	13,113		13,113		13,113			7
8	<b>TOTAL General Services</b>	666,149	436,769	272,273	1,375,191	(18,603)	1,356,588	103,243	1,459,831			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			24,000	24,000	(24,000)						9
10	Nursing and Medical Records	3,952,138	538,143	35,690	4,525,971	(8,468)	4,517,503		4,517,503			10
10a	Therapy			469,251	469,251	(4,385)	464,866		464,866			10a
11	Activities	75,078	873		75,951		75,951		75,951			11
12	Social Services	110,038	1,622	870	112,530		112,530		112,530			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	4,137,254	540,638	529,811	5,207,703	(36,853)	5,170,850		5,170,850			16
	<b>C. General Administration</b>											
17	Administrative	63,361			63,361		63,361		63,361			17
18	Directors Fees							4,438	4,438			18
19	Professional Services			2,110	2,110		2,110	3,500	5,610			19
20	Dues, Fees, Subscriptions & Promotions			38,572	38,572		38,572	(33,640)	4,932			20
21	Clerical & General Office Expenses	147,404	16,307	40,722	204,433		204,433	11,471	215,904			21
22	Employee Benefits & Payroll Taxes			270,237	270,237	18,250	288,487	475,915	764,402			22
23	Inservice Training & Education			1,714	1,714		1,714		1,714			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			3,852	3,852		3,852		3,852			25
26	Insurance-Prop.Liab.Malpractice			91,199	91,199		91,199		91,199			26
27	Other (specify):* <b>BAD DEBT</b>			157,912	157,912		157,912	(157,912)				27
28	<b>TOTAL General Administration</b>	210,765	16,307	606,318	833,390	18,250	851,640	303,772	1,155,412			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,014,168	993,714	1,408,402	7,416,284	(37,206)	7,379,078	407,015	7,786,093			29

\* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name &amp; ID Number VERMILION MANOR NURSING HOME

#0000786

Report Period Beginning:

12/01/02

Ending:

11/30/03

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			200,879	200,879		200,879		200,879			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,592	6,592		6,592		6,592			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			207,471	207,471		207,471		207,471			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					24,000	24,000		24,000			39
40	Barber and Beauty Shops					353	353		353			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			128,027	128,027		128,027		128,027			42
43	Other (specify):* <b>EXCEPTIONAL CARE EXPENSES</b>					12,853	12,853		12,853			43
44	<b>TOTAL Special Cost Centers</b>			128,027	128,027	37,206	165,233		165,233			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,014,168	993,714	1,743,900	7,751,782		7,751,782	407,015	8,158,797			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name &amp; ID Number VERMILION MANOR NURSING HOME

# 0000786

Report Period Beginning:

12/01/02

Ending:

11/30/03

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,473)	V2		4
5	Telephone, TV & Radio in Resident Rooms	(11,005)	V5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(33,640)	V20		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(157,912)	V27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (206,030)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	613,045		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 613,045		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )	\$ 407,015		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops	X		353	V5(3)	41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program	X		12,853	V10,V10a	44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 13,206		47

STATE OF ILLINOIS  
VERMILION MANOR NURSING HOME

Page 5A

ID# 0000786  
Report Period Beginning: 12/01/02  
Ending: 11/30/03

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## Summary A

# 0000786

**Report Period Beginning:**

12/01/02

**Ending:**

**11/30/03**

**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

[illegible]

## Summary B

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		N/A		VERMILION COUNTY	DANVILLE	COUNTY GOVERNMENT

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6 MAINTENANCE-PAYROLL	\$	VERMILION COUNTY	N/A	\$ 117,721	\$ 117,721	1
2	V	18 COMMITTEE		VERMILION COUNTY	N/A	4,438	4,438	2
3	V	19 AUDIT		VERMILION COUNTY	N/A	3,500	3,500	3
4	V	21 ACCOUNTING/PAYROLL		VERMILION COUNTY	N/A	11,471	11,471	4
5	V	22 GROUP INSURANCE		VERMILION COUNTY	N/A	7,974	7,974	5
6	V	22 FICA		VERMILION COUNTY	N/A	380,730	380,730	6
7	V	22 IMRF		VERMILION COUNTY	N/A	87,211	87,211	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$ 613,045	\$ * 613,045	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/01/02 Ending: 11/30/03

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/01/02 Ending: 11/30/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization VERMILION COUNTY, IL  
 Street Address 6 N. VERMILION  
 City / State / Zip Code DANVILLE, IL 61832  
 Phone Number ( 217-431-2553  
 Fax Number ( 217-431-6714

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6 MAINTENANCE-PAYROLL		1		\$ 117,721	\$	1	\$ 117,721	1
2	18 COMMITTEE		1		4,438		1	4,438	2
3	19 AUDIT		1		3,500		1	3,500	3
4	21 ACCOUNTING/PAYROLL		1		11,471		1	11,471	4
5	22 GROUP INSURANCE		1		7,974		1	7,974	5
6	22 FICA		1		380,730		1	380,730	6
7	22 IMRF		1		87,211		1	87,211	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 613,045	\$		\$ 613,045	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	LOAN FROM COUNTY	X		OPERATING EXPENSES	N/A	1/1/97	200,000	104,401	N/A	0.0400	6,592	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 200,000	\$ 104,401			\$ 6,592	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 200,000	\$ 104,401			\$ 6,592	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **VERMILION MANOR NURSING HOME**# **0000786** Report Period Beginning: **12/01/02** Ending: **11/30/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2002 report.			\$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	N/A/	2
3. Under or (over) accrual (line 2 minus line 1).			\$	N/A	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	N/A	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$      For      Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	N/A	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	N/A	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1998	N/A	8		
	1999	N/A	9		
	2000	N/A	10		
	2001	N/A	11		
	2002	N/A	12		
				<b>FOR OHF USE ONLY</b>	
				13	FROM R. E. TAX STATEMENT FOR 2002 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME    VERMILION MANOR NURSING HOME    COUNTY    VERMILION

FACILITY IDPH LICENSE NUMBER    0000786

CONTACT PERSON REGARDING THIS REPORT    \_\_\_\_\_

TELEPHONE (    )    FAX #: (    )

**A.    Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	<b>\$ _____</b>	<b>\$ _____</b>

**B.    Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?           YES           NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C.    Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A.
Square Feet:
74,800

B. General Construction Type:

Exterior
BRICK

Frame
SINGLE STORY

Number of Stories
ONE

C.
Does the Operating Entity?

☒
(a) Own the Facility

☐
(b) Rent from a Related Organization.

☐
(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.
Does the Operating Entity?

☒
(a) Own the Equipment

☐
(b) Rent equipment from a Related Organization.

☐
(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.
List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F.
Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐
YES
☒
NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	INFORMATION NOT AVAILABLE			\$	1
2					2
3	TOTALS			\$	3

Facility Name &amp; ID Number VERMILION MANOR NURSING HOME

# 0000786

Report Period Beginning:

12/01/02

Ending:

11/30/03

**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	138		1974	1974	\$ 2,290,108	\$ 57,253	40	\$ 57,253		\$ 1,708,029	4
5	95		1979	1979	1,961,500	49,038	40	49,038		1,196,728	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	PARKING LOT/GARAGE		1980	1980	16,200		10			16,200	9
10	CONSTRUCTION		1980	1980	92,111	2,303	40	2,303		55,270	10
11	FINAL CONSTRUCTION		1981	1981	6,000	150	40	150		3,450	11
12	PUMP		1982	1982	9,414		10			9,414	12
13	ROOF		1982	1982	40,042		10			40,042	13
14	ROOF		1983	1983	39,569		10			39,569	14
15	ROOF		1984	1984	52,663		10			52,663	15
16	WATER HEATER		1985	1985	27,463		10			27,463	16
17	WATER LINE		1985	1985	5,290		10			5,290	17
18	DRIVEWAY		1985	1985	4,200		10			4,200	18
19	LINT CATCHER		1986	1986	5,981		10			5,981	19
20	PARKING LOT		1986	1986	26,927		10			26,927	20
21	ROOF/DUCT WORK		1986	1986	6,114		10			6,114	21
22	FENCE		1986	1986	609		10			609	22
23	PVC RUB RAILS		1988	1988	2,821	141	20	141		2,198	23
24	CERAMIC TILES		1988	1988	6,872	344	20	344		5,244	24
25	TIME CLOCK/COMPUTER		1988	1988	2,030	101	20	101		1,537	25
26	INCREMENTAL CONDITIONER		1988	1988	17,116	856	20	856		12,838	26
27	WATER METER		1988	1988	1,457	97	15	97		1,457	27
28	400 AMP LINE		1988	1988	3,400	170	20	170		2,649	28
29	CANOPY REPAIR		1988	1988	12,075	604	20	604		9,359	29
30	DOOR O MATIC		1989	1989	1,763	88	20	88		1,292	30
31	AIR CONDITIONER		1989	1989	146,368	7,318	20	7,318		98,548	31
32	HOT WATER STORAGE TANK		1990	1990	4,589	229	20	229		3,134	32
33	CAPITAL IMPROVEMENT		1990	1990	18,139	907	20	907		12,471	33
34	AIR CONDITIONER UNITS		1990	1990	21,470	1,074	20	1,074		14,599	34
35	PUMPS		1991	1991	1,700	85	20	85		1,084	35
36	AIR CONDITIONERS		1991	1991	9,217	461	20	461		5,723	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	FIRE DOORS AND RELATED IMPROVEMENTS	1991	\$ 4,354	\$ 218	20	\$ 218	\$	\$ 2,645	37	
38	PLUMBING	1991	7,162	358	20	358		4,326	38	
39	AIR HANDLER/CORNER GUARDS	1991	4,028	201	20	201		2,416	39	
40	ROOF REPAIR	1991	10,500	525	20	525		6,738	40	
41	FIRE HYDRANT	1991	2,185	109	20	109		1,400	41	
42	GENERATOR	1992	70,808	3,540	20	3,540		41,231	42	
43	PLUMBING	1992	62,884	3,144	20	3,144		36,568	43	
44	LIGHT FIXTURES	1992	1,395	70	20	70		803	44	
45	AIR CONDITIONERS	1992	24,201	1,210	20	1,210		13,769	45	
46	ROOF REPAIRS	1993	38,982	1,949	20	1,949		20,369	46	
47	WALK IN FREEZER	1993	11,400	570	20	570		6,080	47	
48	MASTER STATION IMPROVEMENTS	1993	3,215	214	20	214		2,249	48	
49	SMOKING ROOM	1993	6,511	325	20	325		3,392	49	
50	LOUNGE WALL	1993	1,004	50	20	50		514	50	
51	KITCHEN IMPROVEMENTS	1993	9,952	498	20	498		5,123	51	
52	80 GALLON WATER HEATER	1994	5,987	299	20	299		2,892	52	
53	ACTIVATOR PARTS	1994	1,190	59	20	59		573	53	
54	DAMPERS	1994	3,082	154	20	154		1,451	54	
55	CALL SYSTEM	1994	3,427	171	20	171		1,541	55	
56	GARAGE	1994	13,254	663	20	663		5,965	56	
57	BOOSTER HEATER	1995	4,320	432	10	432		3,780	57	
58	CALL LIGHT SYSTEM	1995	3,577	358	10	358		3,101	58	
59	FOLDING PARTITION	1995	4,880	488	10	488		3,904	59	
60	REWIRE GARAGE	1995	650	33	20	33		262	60	
61	EXHAUST SYSTEM	1996	5,347	535	10	535		4,234	61	
62	CONCRETE WORK-FRONT ENTRANCE	1996	1,050	70	15	70		519	62	
63	CONCRETE WORK-DRIVEWAYS	1996	10,170	678	15	678		4,972	63	
64	CANOPY	1996	19,619	1,308	15	1,308		9,374	64	
65	TILE REPLACEMENT	1996	1,129	113	10	113		791	65	
66	ROOF REPAIR	1997	30,645	1,532	20	1,532		9,831	66	
67	AIR CONDITIONER UNITS	1997	15,320	766	20	766		4,788	67	
68	REPAIR DRIVE	1997	2,900	290	10	290		1,837	68	
69	WATER HEATER	1998	6,200	620	10	620		3,255	69	
70	TOTAL (lines 4 thru 69)		\$ 5,224,536	\$ 142,769		\$ 142,769	\$	\$ 3,580,775	70	

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,224,536	\$ 142,769		\$ 142,769		\$ 3,580,775	1
2	CAPITAL IMPROVEMENT	1998	1,013	102	10	102		506	2
3	ROOF	1998	21,809	2,181	10	2,181		11,087	3
4	AIR CONDITIONER UNITS	1998	9,160	458	20	458		2,328	4
5	AIR CONDITIONER UNITS	1998	8,580	429	20	429		2,145	5
6	NEW ROOF	1999	22,973	1,149	20	1,149		4,979	6
7	AIR CONDITIONER UNITS	1999	49,921	2,496	20	2,496		10,816	7
8	CANOPY REPAIR	1999	7,630	382	20	382		1,623	8
9	GENERATOR	2000	7,951	398	20	398		1,426	9
10	WATER HEATER	2000	8,368	418	20	418		1,393	10
11	CONDENSER	2000	2,350	118	20	118		383	11
12	CANOPY REPAIR	2001	7,700	513	15	513		1,454	12
13	HOT WATER HEATER	2001	1,634	163	10	163		421	13
14	ELECTRIC BOOSTER HEATER	2001	1,639	164	10	164		396	14
15	BOILER REPAIR	2001	23,800	1,587	15	1,587		3,437	15
16	AIR CONDITIONER UNITS	2002	8,367	418	20	418		418	16
17	LIGHTING/C SECTION RENOVATIONS	2002	8,402	420	20	420		420	17
18	PARKING LOT IMPROVEMENTS	2003	4,800	80	15	80		80	18
19	ROOFING	1994	38,981	1,949	20	1,949		17,541	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,459,614	\$ 156,194		\$ 156,194		\$ 3,641,628	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 195,944	\$ 36,549	\$ 36,549	\$	VARIOUS	\$ 128,553	71
72	Current Year Purchases	36,287	3,216	3,216		VARIOUS	3,216	72
73	Fully Depreciated Assets	775,953				VARIOUS	775,953	73
74								74
75	TOTALS	\$ 1,008,184	\$ 39,765	\$ 39,765	\$		\$ 907,722	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT TRANS	DODGE VAN- 1989	1989	\$ 25,461	\$	\$	\$	5	\$ 25,461	76
77	RESIDENT TRANS	FORD VAN 1996	1996	22,296				5	22,296	77
78	MAINTENANCE	FORD TRUCK 1993	1993	19,169				5	19,169	78
79	RESIDENT TRANS	2003 CHEVY VAN W LIFTS	2002	24,602	4,920	4,920		5	4,920	79
80	TOTALS			\$ 91,528	\$ 4,920	\$ 4,920	\$		\$ 71,846	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,559,326	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 200,879	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 200,879	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,621,196	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**1. Name of Party Holding Lease:** N/A

**2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?**

**If NO, see instructions.**

☐ YES      ☐ NO

**10. Effective dates of current rental agreement:**

## Beginning

**Ending**

**11. Rent to be paid in future years under the current rental agreement:**

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: \*

**15. Is Movable equipment rental included in building rental?**

16. Rental Amount for movable equipment: \$ Description:

**(Attach a schedule detailing the breakdown of movable equipment)**

	1	2	3	4	
	Use	Model Year and Make	Monthly Lease Payment	Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

**\* If there is an option to buy the building, please provide complete details on attached schedule.**

**\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.**

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 818,093	\$	1
2	Cash-Patient Deposits	36,905		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,132,533		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,987,531	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	5,459,614		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,099,712		16
17	Accumulated Depreciation (book methods)	(4,621,196)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,938,130	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,925,661	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 227,896	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	36,905		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	250,132		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<b>DUE TO OTHER FUNDS</b>	1,033,610		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,548,543	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,548,543	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,377,118	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,925,661	\$	48

\*(See instructions.)

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	LINE 39(8)	52 visits			24,000		52	24,000	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$ 24,000	\$	52	\$ 24,000	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,119,634</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,119,634</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>252,684</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>PROPERTY- COUNTY CAPITAL FUND</b>	<b>4,800</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>257,484</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,377,118</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,939,685	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,939,685	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,473	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 3,473	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,012	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,012	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>MISCELLANEOUS- SEE ATTACHED</b>	58,296	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 58,296	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,004,466	30

2			
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,375,191	31
32	Health Care	5,207,703	32
33	General Administration	833,390	33
<b>B. Capital Expense</b>			
34	Ownership	207,471	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	128,027	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,751,782	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	252,684	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 252,684	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **VERMILION MANOR NURSING HOME**# **0000786**Report Period Beginning: **12/01/02**Ending: **11/30/03****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,081	2,312	\$ 45,679	\$ 19.76	1
2	Assistant Director of Nursing	2,012	2,217	36,941	16.66	2
3	Registered Nurses	48,983	50,771	944,896	18.61	3
4	Licensed Practical Nurses	67,382	70,925	888,065	12.52	4
5	Nurse Aides & Orderlies	232,108	246,461	1,965,947	7.98	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,236	1,365	12,502	9.16	9
10	Activity Assistants	7,854	8,563	62,576	7.31	10
11	Social Service Workers	8,414	9,683	110,038	11.36	11
12	Dietician					12
13	Food Service Supervisor	7,824	8,441	75,848	8.99	13
14	Head Cook	11,085	12,301	101,854	8.28	14
15	Cook Helpers/Assistants	44,617	46,934	256,779	5.47	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	16,475	18,042	136,305	7.55	18
19	Laundry	14,771	15,836	95,363	6.02	19
20	Administrator	1,880	2,136	63,361	29.66	20
21	Assistant Administrator					21
22	Other Administrative	3,877	4,426	59,141	13.36	22
23	Office Manager					23
24	Clerical	11,831	12,931	88,263	6.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	7,602	8,509	70,610	8.30	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	490,032	521,853	\$ 5,014,168 *	\$ 9.61	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 17,343	1/3	35
36	Medical Director				36
37	Medical Records Consultant		1,940	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,400	10/3	39
40	Physical Therapy Consultant		5,101	10/3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>FR&amp;R</u>		2,110	19/3	46
47	<u>COMPUTER SUPPORT</u>		7,549	21/3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 36,443		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	173	\$ 7,751	10/3	50
51	Licensed Practical Nurses	148	6,579	10/3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	321	\$ 14,330		53

Facility Name &amp; ID Number VERMILION MANOR NURSING HOME

# 0000786

Report Period Beginning: 12/01/02

Ending: 11/30/03

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount		
EDIE HESSER	ADMINISTRATOR	0	\$ 43,427	Workers' Compensation Insurance	\$ 102,451	IDPH License Fee	\$		
JONI LIVENGOD	INTERIM	0	19,934	Unemployment Compensation Insurance	25,294	Advertising: Employee Recruitment			
	ADMINISTRATOR			FICA Taxes	380,730	Health Care Worker Background Check			
				Employee Health Insurance	137,012	(Indicate # of checks performed 65)	780		
				Employee Meals	18,250	DUES & FEES	2,291		
				Illinois Municipal Retirement Fund (IMRF)*	87,211	BOOKS & PERIODICALS	1,861		
				GROUP LIFE INSURANCE	7,974				
				EMPLOYEE PHYSICALS	980				
				EMPLOYEE FRINGE	4,500				
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 63,361						
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)			
Description			Amount						
			\$						
TOTAL (agree to Schedule V, line 17, col. 3)			\$						
(Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount		
FR&R	MEDICAL CONSULTANT	\$ 2,110			\$	Out-of-State Travel	\$		
						In-State Travel			
						Seminar Expense			
						Entertainment Expense	( )		
						(agree to Sch. V, line 24, col. 8)			
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL					
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 2,110						

\* Attach copy of IMRF notifications

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)**

[illegible]

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? YES, EXCEPT R/N'S
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. COUNTY NHA - \$1700
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 55,148 Line 10/2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 128,027  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 18,250 Has any meal income been offset against related costs? YES Indicate the amount. \$ 3,473
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? YES If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
- c. What percent of all travel expense relates to transportation of nurses and patients? 75%
- d. Have vehicle usage logs been maintained? YES
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: CLIFTON GUNDERSON LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. SEE ATTACHED
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.